Medical Part 1 – History and Physical for overnight students and students participating on a sports team

Health Center – School Year 2024-25

Student's Name (Last, First, Middle): Click or tap here to enter text.

Birthday (Mo. Day Yr.): Click or tap to enter a date.

Sex: [ ]  M [ ]  F

Address (Number, Street, City, Zip): Click or tap here to enter text.

Phone No.: Click or tap here to enter text.

Parent/Guardian Names: Click or tap here to enter text.

Where do you usually take your child for routine medical care?

* Name: Click or tap here to enter text.
* Address: Click or tap here to enter text.
* Phone No.: Click or tap here to enter text.

Where do you usually take your child for dental care?

* Name: Click or tap here to enter text.
* Address: Click or tap here to enter text.
* Phone No.: Click or tap here to enter text.

From what other source does your child receive health care?

* Name: Click or tap here to enter text.
* Address: Click or tap here to enter text.
* Phone No.: Click or tap here to enter text.

# ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, has your child had any problem with the following? Please check "Yes" or "No" for each.

Allergies (Food, Insects, Drugs, Latex): [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Allergies (Seasonal): [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Asthma or Breathing Problems: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Behavioral or Emotional Problems: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Birth Defects: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Bleeding Problems: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Cerebral Palsy: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Dental: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Diabetes: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Ear Problems or Deafness: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Head Injury: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Heart Problems: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Hospitalization (When, Where): [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Lead Poisoning/Exposure: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Learning Problems/Disabilities: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Limits on Physical Ability: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Meningitis: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Prematurity: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Problem with Bladder: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Problem with Bowels: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Problem with Coughing: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Seizures: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Serious Allergic Reactions: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Sickle Cell Disease: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Speech Problems: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Surgery: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Other: [ ]  Yes [ ]  No

* Comments: Click or tap here to enter text.

Does your child take any medication?

[ ]  Yes [ ]  No

Name of medication: Click or tap here to enter text.

## Is your child on any special treatments? (nebulizer, epi-pen, etc.)

[ ]  Yes [ ]  No

Treatment: Click or tap here to enter text.

## Does your child require any special procedures? (catheterization, etc.)

[ ]  Yes [ ]  No

Please describe: Click or tap here to enter text.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click or tap to enter a date.

Parent/Guardian Printed Name: Click or tap here to enter text.

PB/LB/cic:2/6/24